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ABSTRACT

An early intervention project for preschool handicapped children is described. Specific program goals (including improved functioning in social, emotional, communication, and preacademic areas) are listed, and roles of the interdisciplinary staff members are considered. Among evaluation approaches discussed are psychological measures, family histories, and analysis of mother-child interaction. Primary treatment modes are explained to be psychodynamic and psychoeducational. Examples of children referred to the 6 week therapeutic classroom, the intensive day treatment program, and the home visit program are given. (CL)

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A Description of the Hawthorn Center Early Intervention Program

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Since the implementation of Michigan's Special Education Act the demand for services for preschool handicapped children has increased substantially. At Hawthorn Center, a comprehensive children's psychiatric treatment facility which was opened in 1956, between July, 1975 and June, 1976 fifty children under age six were seen for outpatient treatment.

Communication with Wayne County Special Education and the Michigan Department of Special Education indicated that even more preschoolers would be likely to need evaluations and services in the future. These departments pointed out that because school districts were mandated by Federal law to conduct Child Find Projects, an increasing number of children under school age were being found who presented social, emotional and behavioral problems necessitating multidisciplinary intervention.

Assessing the needs of these children and providing special programming presented problems for local school districts. It was found that:

(1) a simple screening or one day evaluation of preschool children often did not yield sufficient diagnostic information. Understanding the complexities of their problems and planning appropriate programs requires a more detailed and refined assessment procedure than schools can provide.

(2) many parents of these children need help themselves on how to more effectively manage and to effectively meet the emotional needs of their children. Although many school systems provided some services for parents, often intensive intervention was necessary.

(3) as preschool early intervention with children displaying social and emotional problems is relatively new, the staffs of these programs require support and consultation.

Objectives

In July, 1976 the project was initiated and was funded through Title 1. The major objective of the Early Intervention Service was to provide an intensive day- school program for preschool children who were experiencing difficulties in social, emotional, communication and pre- academic functioning. In addition, an important emphasis of the program was the involvement of the parents in both the therapeutic and educational process. While the child is presented as the " patient " and is often targeted for treatment, our feeling has always been that problems involve the whole family and therefore other family members must be active participants in the treatment if changes are to occur.

Through comprehensive intervention in the preschool years it was hoped that the need for special programming for children served by the project would be reduced by the time the children reached school age. The specific goals of the project were:

(1) to provide and educational and therapeutic treatment program that would result in improvemnts in preschool children's functioning in the social, emotional communication and preacademic areas.

(2) through the parental component to develop parental insight into their child's behavior and development so that they would develop more effective techniques of managing and socializing their children.

(3) to provide comprehensive psychiatric, psychological and educational assessments of preschool children that would lead to their placement into appropriate community programs.

(4) to enlighten and provide technical assistance to local community programs and agencies regarding the identification and treatment of preschool children with emotional impairments.

Scope of Project

During the first three years of the program the number of evaluations increased steadily. Table 1 presents the number of children referred to the service for evaluations during those years by age.

Table 1

Children Evaluated for Early Intervention

Year	1 year olds	2 year olds	3 year olds	4 year olds	5 year olds
1976	2	4	7	14	10
1977	1	4	20	11	27
1978	2	7	14	25	23
1979	2	11	13	24	24
1980 (to present)	1	2	0	4	5

The number of children evaluated has increased from 37 in 1976 to 74 in 1979. The projected number of children to be seen in 1980 is close to 100. Presently two evaluations are completed each week throughout the year.

Staff Composition

Because the services provided to families of preschool children involve psychiatric, psychological, social work, and educational intervention, the staff is multidisciplinary. Unlike many intervention programs which are hierarchical in terms of staff roles, in the present program, the roles overlap.

Three child psychiatrists serve to supervise early intervention services by checking each of the weekly evaluations and by providing clinical supervision for therapy cases.

Five staff psychologists (two full time and three part-time) are responsible for comprehensive psychological test batteries and family history evaluations.of referred children, serve as primary therapists for children referred to the service and for parents referred for treatment, and, function as co- teachers in two therapeutic classrooms which will be described below.

Four staff social workers (one full time and three part-time) are responsible for historical evaluations of referred children, serve as primary psychotherapists for preschool children and their parents, and, also function as co-teachers in the therapeutic classrooms. One senior staff social worker also supervises clinical work in weekly supervisory meetings with therapists.

Finally, a certified special education preschool teacher is the primary figure in a six week therapeutic classroom and in a long term, ongoing classroom. The classroom teacher as well as social workers and psychologists also make therapeutic home visits to families unable to utilize services in the hospital setting. The clinical skills of this teacher are also utilized in her function as a co- leader to a parent group which is run in conjunction with the longer term therapeutic classroom.

Each of the staff members is also responsible for participating on various committees involved in research, staff and student training and, community interrelationships with the program.

Activities

Evaluations

Every child who is referred to the Early Intervention Service is given a complete psychiatric and psychological evaluation generally lasting up to six hours. Table 2 presents the kinds of problems referred for evaluations.

Table 2

Problem	Number of Patients	Percentage
Temper Tantrums	33	25
Aggression	16	12
Delayed Speech	15	11
Hyperactivity	14	11
School Behavior Problem	10	8
Withdrawal	3	2
Destructiveness	3	2
Other	40	29

Table 3 presents a list of the referral sources over the last four years.

Table 3

Referral Sources

Source	Patients	Percentage
Medical	43	31
Schools	38	27
Hawthorn Staff	17	13
Parents or Relative	14	11
Mental Health Agencies	10	8
Other	12	10

(Based on initial 134 patients referred to project July, 1976- August, 1979)

A staff psychologist or psychological intern under the supervision of a staff psychologist in the program administers a complete psychological test battery. Interns first test while being observed by a supervising psychologist before being permitted to test preschoolers.

The Wechsler Preschool and Primary Scale of Intelligence is used as a measure of intellectual functioning in children above the age of four. The Stanford- Binet Intelligence Scale is used for children between the ages of two and four, and the Bayley Developmental Scale is used to assess development and psychological functioning in children below age two and in those children who require such primary testing. The Geometric Designs subtest of the Wechsler scale, the Bender Visual Motor Gestalt Test or the Santucci perceptual-motor test are used to assess perceptual-motor functioning. Finally, a projective drawing of a person and a family and, projective elaborations, a mutual story telling technique (Gardner, 1971), or the Despert Fables (Kramer, 1968) may be used to screen personality dynamics. Gross neurological testing is done by the checking psychiatrist during the psychiatric interview. In addition, where a language functioning assessment is required the child is referred to the Language Clinic which is part of the regular Hawthorn Center school program. Every psychological test battery is first checked by a supervising psychologist before being discussed with the supervising psychiatrist of the day.

While the child is being tested, another staff member takes a complete family history using a form which was designed for preschool aged children. The framework of the history form is Dr. E.J. Anthony's Risk Assessment Profile (Anthony, 1974). Seven areas of potential vulnerability are explored through detailed questioning. These are :

(1) Genetic loading- exploration of physical and mental illness in the nuclear

and extended family;

(2) Reproductive loading- prenatal maternal and fetal health; paranatal difficulties in the mother, eg., delayed labor, instrumental delivery, etc., and in the child, eg., abnormal presentation, signs of fetal distress, etc.;

(3) Constitutional loading- exploration of constitutional and temperamental factors outlined by Drs. Alexander Thomas, Stella Chess, and Herbert Birch (1968), i.e., activity level, adaptability, approach-withdrawal, biological rhythms, intensity of response, mood, attention span and persistence, distractibility, stimulus thresholds.

(4) Developmental loading- exploration of critical developmental milestones, preschool crises, etc.

(5) Physical health loading- exploration of illnesses, accidents, hospitalizations, allergies, medications;

(6) Environmental loading- explorations of problems within the family including institutional or foster placement and socio- economic handicap;

(7) Traumatic loading- exploration of medical trauma, physical or sexual assault, loss of family member, emotional shock, or social trauma.

In addition, the profile considers developmental lines (A . Freud, 1965) and the processes of mother-child bonding (Klaus, M.H. and Kennell, J.H., 1976), and separation- individuation (M. Mahler et al., 1975). Specific sections focus on the initial match or mismatch between mother and infant as they meet for the first time after delivery and the father's input after the birth of the child. Also, the development of object relationships through the separation-individuation process as described by Margaret Mahler and her colleagues (1975) in which the child begins to function through the development of a sense of a separate, autonomous identity.

We are interested in the effects of a mother who rewards dependent behavior from birth to the parent who encourages and supports physical separation and and individuation during the first year of life.

The final part of the evaluation is a filming or video-taping of the mother and child in a three part unstructured play situation in the therapeutic classroom. The session is divided into three segments : (a) mother and child playing together, (b) child engaged in solitary play, (c) mother and child cleaning up materials and preparing to leave the room. Each segment lasts for seven minutes and is observed by the psychologist who did the testing and the historian who are behind a one way mirror.

In the first segment we are interested in the ability of the mother and the child to play together. The observed interaction may enable the teacher and the child's therapist to assess the child's responsiveness to another adult, and, the child and mother's characteristic mode of interaction, eg., incorporative, eliminative, retentive, intrusive (Erikson, 1964). Among the areas observed are:

(1) who takes the lead in the interaction and is there clashing or attunement (Kestenberg 1975)?

(2) frequency of contact between mother and child.

(3) nature of the contact (distal through speech or eye contact vs. proximal through touching or hovering near).

(4) emotional tone of the interaction.

(5) whether the communication between parent and child is primarily action oriented or whether the actions are verbalized.

(6) intensity and duration of the contact.

(7) the child's use of space in relation to the mother.

(8) anxiety and frustration tolerance as seen in the mother and child.

In the second segment the child is asked by his or her mother to play alone while the mother reads a book or magazine on a couch situated at a distance from the play area. What is observed during this segment is how the child deals with separation in the physical presence of the mother. In effect, (a) can the child be self- directed or is it necessary for mother to structure activities ? (b) does the child attempt to re-engage the mother in play? (c) can the child and mother tolerate physical distance ? Moreover, we are interested in observing the following:

(1) the toys and the spaces that the child selects;

(2) the child's and mother's emotional tone during solitary play, activity level, coverage of space, stereotypy of actions;

(3) content and themes of play;

(4) curiosity in play environment.

In the final segment in which the mother asks the child to clean up materials we are interested in the mother's ability to step in and to set consistent limits and to follow through on her directions. Of major importance at this point is the child's response to her instructions.

The play observation concludes the initial part of the evaluation. The information obtained from the testing, history and observation is then shared with the checking psychiatrist who supervises the evaluation and preliminary recommendations. After the supervision is completed the child psychiatrist interviews the child. A final summary session is held with the psychologist and the historian at which time recommendations for treatment are discussed. These recomendations are then shared with the parents by the historian.

Treatment

The treatment component of the program is multi-faceted and structured to meet the needs of individual families. The primary modes of treatment are psychodynamic and psycho-educational. The common denominator of all treatment modes used is the involvement of the parents and when necessary, other family members. Parents are required to participate in all aspects of the program and are seen either individually, with the child who is in treatment in the therapeutic classroom, or in family therapy as a unit. By treating the parent and the child concurrently, interferences presented by parental psychopathology can be explored. Anna Freud (1960) in discussing therapy techniques with children writes,

> " Where the neurotic symptom, the conflict or the regression of a child is anchored not only in the young patient's own personality but held in place further by powerful emotional forces in the parent to whom the child is tied, the therapeutic action... may be slowed up, or in extreme cases, made impossible. "

Through simultaneous or concurrent treatment the parent may begin to understand his or her conflicts and how they relate to the child's functioning. Where insight and understanding take place, the parent(s) may be able to relinquish the pathological hold on the child.

Each child and his family admitted to the program are assigned to a therapist who is responsible for ( ) formulating and carrying out a treatment plan to meet the individual needs of the child and his family.

Outpatient Treatment

Given the large number of children referred for services, the dominant mode of treatment is outpatient therapy in which a

therapist sees the child once or twice a week in individual sessions and sees the parent(s) for treatment on another day. The mode of therapy used with preschool children who are involved in the program is primarily psychodynamically oriented play therapy. Contact with parents may be as limited as monthly brief interviews to focus on the child's progress or as simultaneous treatment in which the parent or parents are seen for full sessions once a week to work on individual or marital difficulties which may be interferring with the child's functioning and contributing to problems in the child.

Family therapy is also used as a major outpatient treatment modality. Through family therapy siblings may be involved in the treatment program as the entire family works to re-establish a positive family system.

Parent groups have also evolved for parents of children who are participating in outpatient treatment or in one of the therapeutic classrooms. The goals of both types of parent groups are similar:

(1) To share feelings around having a child who is experiencing difficulties;

(2) To provide mutual support to other parents;

(3) To exchange ideas related to child management;

(4) To attempt to gain an understanding of their children as well as themselves;

(5) To develop social contacts. Parents are often isolated outside of treatment and through group participation are able to develop social relationships which continue outside of the treatment setting.

Six Week Therapeutic Classroom

The six week therapeutic classroom concept initially was developed to give the clinical staff an opportunity to observe parents and children for a longer period of time before diagnostic statements were made. Children referred to the six week program were seen as probably needing more intensive treatment than those referred for outpatient treatment. Over a six week period children could be observed in a small group and their parents could be observed interacting with them during specific periods two mornings a week.

In terms of staffing, the primary figure in the classroom is a certified preschool special education teacher who is responsible for curriculum planning with two therapists who make up the classroom clinical team. One of the therapists works in the classroom with the teacher during each two hour session. The other therapist assigned to the group works with the parents behind a one way mirror while the class is in session. Therapists rotate days in the classroom and behind the one way mirror. Each of the therapists is assigned to two or three children in the classroom and their parents for individual psychotherapy in conjunction with classroom participation and for follow up services after the child completes the six week period. There are some children who are re- enrolled in this program at the end of six weeks because it is felt that such a group is appropriate for the family's needs.

The scope, format, and materials used in the classroom will be described below.

Bonnie is an example of a girl referred to the six week

program. She was referred at age five because of poor performance in her kindergarten classroom. She evidenced an extremely high activity level, high distractibility and poor perceptual organization. Her behavior, as described by her kindergarten teacher often seemed purposeless, inconsistent, and out of context. Her ideas were often described as bizarre and disorganized.

Prior to her evaluation she had been attending kindergarten five mornings a week for 2½ hour sessions. In her psychological evaluation Bonnie was extremely manipulative and at times blatantly provocative and profane. Because of her profanity and temper outbursts the testing could not be completed although it was estimated that she had above average potential. During her psychiatric interview she was similarly seductive, provocative and highly narcissistic. She appeared to be relating on a need gratifying level in that she seemed to be more concerned about what she could get from the interviewer rather than in relating to him as an adult figure.

Bonnie's tangential, irrelevant responses to questions were clearly self controlled and a means of avoiding dealing with threatening material. It was felt that participation in the six week program would clarify some of her emotional needs.

Intensive Day Treatment Program

A number of children who required intensive psychotherapy were previously unable to be seen in the regular day treatment program at Hawthorn Center because they were too young. At the same time, their needs were more intense than could be handled in another type of treatment program . These children evidenced such problems as (a) severe expressive or receptive language disorders; (b) disorganized relatively unfocused behaviors; (c) difficulties in verbal comprehension; (d) resistence to discipline and to external controls; (e) unawareness of adults and/or other children; (f) avoidance of eye contact; (g) immaturity and difficulties in listening and following directions.

An afternoon, full year preschool class was started to begin to deal with these more extreme problems. The class meets four days a

week for two hour sessions. During half of each session a therapist remains in the classroom with the teacher and spends 20 minutes with each of the children individually. The maximum number of children in this group is four with all of the children being assigned to the therapist who works closely with the special education teacher to plan activities. The therapist sees each of the children's parents once a week in individual psychotherapy. In addition the parents participate in a parent group in which the teacher and therapist are co- leaders and parents have the opportunity to share experiences within the small group which meets on a bi-weekly basis.

Bobby is an example of a child referred to the intensive treatment program. At age 4½ he was referred by his preschool teacher because of isolative and perseverative behaviors in his nursery school program. There was no involvement with other children and intrusion into his isolative behaviors resulted in violent temper outbursts. Self- hitting and destructive behaviors accompanied each of his tantrums which lasted for ten to fifteen minutes unless he was physically held.

When he was interviewed there was a striking absence of relatedness observed. He was preoccupied with inanimate objects which he twirled in front of him. He was, however, able to respond to some requests spontaneously confusing the clinical staff who observed him. It was also interesting to note that despite his atypical behaviors, at times, he was responsive to adults and able to communicate his needs. Still he appeared immature, insecure, and intensely frightened of separations from familiar persons or places. Because of the question of Borderline pathology Bobby was referred for intensive psychotherapy and classroom participation.

Home Visits

Initially the six week classroom program included children below the age of three. These children were seen, with their parents, twice a week in the same manner as the children in the six week program outlined above. However, it was increasingly found that parents found it difficult to keep consistent appointments because of problems with baby sitters for other siblings, schedules, etc.

In addition, given the level of development in the area of play and social skills, " grouping " these children was exceedingly difficult. A home visit program was set up in which the special education teacher and/or a therapist assigned to the family went into the home to work with the family as a unit. The person(s) who made the home visit depended upon the specific needs of the family and the family situation. At times it was appropriate for the teacher to work with the child on basic preacademic activities while the parent was simultaneously seen by a therapist. Often, where more intensive involvement was necessary to deal with specific emotional problems interferring with the parent-child relationship, the therapist worked with both parent and child in an attempt to help the parent deal with specific conflicts.

Jimmy is an example of a child whose family benefited from home visits. He was a two year, five month old boy who was referred because of severe bowel retention which began immediately after his mother returned home from a brief hospitalization. All medical tests had proven negative and Jimmy's mother was extremely anxious about his retention which lasted up to five days.

Jimmy's mother was strikingly guarded and expressed a fear about being involved in therapy with other parents. It was felt that because of the child's age and the mother's fears that home visits would be a way to make initial contact with her and then eventually help her to be involved with other parents in a parent group.

Other Early Intervention Projects

In addition to the clinical services available to families, there are a number of other activities which are part of the Early Intervention Service. A primary interest is staff training and the training of students who are trained at Hawthorn in the departments of Psychiatry, Psychology, Social Work and Education. In the fall, 1980 a training program will start involving students from each of these disciplines on different levels depending on

availability of time. Two trainees from each of the departments mentioned will be trained to work with preschool aged children. The students will be supervised by a full time staff member of the Early Intervention Service in each of the disciplines. They will participate in all of the activities within the project including testing, history taking and psychotherapy. In addition, three seminars are scheduled for these students and other university students interested in preschool work. The first seminar will focus on emotional development of the preschool child from 0 to 5. The course will be taught from a psychodynamic framework and will also focus on the work of Piaget. Students will participate in this seminar for a period of 15 weeks. In addition, a member of the Department of Psychiatry will initiate a course in psychotherapy with the preschool child and will focus on critical issues in the therapy of preschoolers. Clinical material will be brought in to compliment some of the theoretical material presented. Finally, a seminar on the education of the preschool child will focus on teaching techniques and curricula for young children and will be available to student teachers completing their student teaching experiences within the mental health center.

In addition to the training of university students, there is ongoing clinical training of all staff personnel in addition to clinical supervision which is required of all therapists. The entire Early Intervention staff meets once a week for an hour-and-a-half. Two meetings during the month are case presentations which are discussed in terms of dynamics and treatment. The alternate meetings focus on critical clinical issues such as diagnosis, appropriate group placements, staff interactions, and committee activities which all staff members participate in. The three major committees that are ongoing at this point are (1) research, (2) community interrelationships with the mental health center and (3) staff training.

Six members of thr program have been involved in generating a research project with specific emphasis on follow up. A research design is being set up to study specific clusters of children who have been evaluated and/ or treated through the program.

Four major groups of children are being considered. The first group involves children who have been referred for evaluations and have tested out within the Superior or Very Superior range of intellectual functioning. Two groups of children are being studied; those who have participated in the program and those who were seen as having no emotional impairment and not given any treatment. This latter group is of major concern for while no pathology was observed, parents still expressed concerns about particular behaviors. An important area of investigation is whether or not these children developed symptoms after they were evaluated and how those symptoms, if present, are tied into the parent's anxieties which were perhaps overlooked during the initial evaluations.

A related group of children are those with deferred diagnoses. These are children for whom re-evaluations are recommended after a period of three to six months. Some of these children evidence developmental lags during the initial evaluations while others present questions relating to making a differential diagnosis, eg., autism, mental retardation, brain damage. An important research question is again related to what happens to children who are referred for treatment but not given any specific therapeutic program or involvement ?

A third group of interest is a group of electively mute

children. Five such children have participated in the therapeutic classroom and all are presently attending regular schools without special education services. For this group it would be important to analyze different aspects of the treatment program which contributed to the maintainance of healthy emotional development.

The final group of children are those who have suffered through parental separation and divorce. There has been a great deal of recent research on the effects of divorce on children. Kelly and Wallerstein (1976) and Wallerstein and Kelly (1975, 1974) have followed children of divorce from preschool age to adolescence in non- clinical populations. It would be important to compare clinical and non- clinical populations to examine some of the variables that contribute to emotional breakdown in young children.

The final committee which is in progress is attemting to establish ties with inner city agencies in order to begin out-research work. We are interested in training, consultation, and therapy with low income, inner city groups where staff members can go out into the community rather than have these families struggle to come to the mental health center. It is felt that work in the inner city with preschool children can make a major contribution to mental health and at this point state and local contacts are being made.

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The therapeutic classroom's primary focus is to:

1) identify children's problem behavior
2) make observations of the child's developmental level and play skills
3) dialogue with children about their feelings
4) interpret the children's behavior and interactions with peers
5) provide alternate behavior
6) support and reinforce strengths and positives
7) model effective behavior management techniques for parents to observe and children to respond to adults

Behaviors children in the class exhibit and possible reasons for referral could be:

violent temper tantrums

aggressive behavior

elective mutism

destructive/negative behavior

poor peer interactions

toileting problems

eating problems

sleep disturbance

poor impulse control

high activity level

developmental delay

refusal to acknowledge feelings

Referrals we received from:

1) pediatricians

2) school district or nursery program

3) parents themselves

Children are grouped into the classroom with consideration given to their chronological age, developmental stage, and presenting problems. A classroom group consists of 3-6 children ranging in ages of 3-6 years. The group meets twice a week for two hour sessions with both the child and parent attending. The parent involvement is essential for gains in the family. The child realizes that the whole family is here to work on the problem and they are coming to a special school.

The classroom staff is a special education preschool teacher and a therapist (psychologist or social worker) with the teacher as the consistent person in the class.

The physical arrangement of the room provides play space and play materials for various channels of play interaction: Solitary play alone, cooperative play with peers, play with adults, play with structured materials, or creative drama play with child's imagination. The play space of the room is designated as certain areas and this is part of the structure of the class.

Billy, a destructive child with peer interaction difficulties can use the block building area to interact with peers and learn he must ask to use a toy and cannot destroy someone elses property. John, an aggressive child with his siblings, plays in the housekeeping corner pretending he is the mother spanking the dolls and kicking the stuffed animals. Jamie, an elective mute, uses the sand andwater table as it is an appealing activity and speech is encouraged to

participate. Scott, a fearful child, uses the role play area with a dollhouse, grocery store, and doctor's office to dress up as a doctor and check dolls and other children with the doctor kit. He expresses fears and concerns he had when he was in an accident and went to the hospital.

The room is an appealing environment and the children easily become comfortable in their new setting.

The curriculum design has an extensive focus on affective activities and affective teaching materials. There is continued daily reinforcement and diagnosis of pre-academic skills with most daily emphasis on the children socializing with their peers, talking and communicating with other children and adults, and participating in classroom activities with appropriate behavior. Each class session includes eight different activity times of approximately 10-15 minutes for each activity. The same daily schedule is used every day to help organize the child's routine of activities. It is important to tell the child what each time is called and when one activity is almost finished, prepare them for the transition and tell them what is next. Example: "Story time is almost over, and Music Time will be next."

An example of a routine day would be: Free Play Time, Talk Time, Story Time, Music Time, Work Time, Exercise Playroom Time, Art Time, Snack Time, and Play Time with parents. The activity level of free movement of space time and structured group time alternates with each activity. Depending on the group's needs, there are varied group and individual activities such as group story time and individual art time. For each activity, the group changes place or position with talk time at the table, story time sitting on a piece of tape on the floor, or exercise time is in the playroom. The child's program is highly individualized with

individual goals and performance objectives, class management strategies, interpretive verbal techniques and themes for class activities jointly planned by the staff team. This staff communication is essential to meet the needs of the family through the therapeutic classroom. The team meets 30 minutes before each session to review daily class activities, any important issues with each child and their family, and any specific handling for specific behaviors. The team also meets immediately following each class to debrief on the class and parents observations.

Having the parent involvement each class day aids in receiving current information about the child's specific needs so that stories, discussion topics at talk time, puppet play, and role play situations can be scheduled into class time and the issue or problem is dealt with in class. For example: Susie's mother told the teacher Susie had run away from her at a shopping center. Susie refused to talk about it at talk time denying it had happened but with a book at story time about running away, she shared her fears and explored feelings that she and mother had when she ran away.

Some of the frequently used discussion topics at talk time are (1) making friends, (2) going to school (3) the child's family (4) why the children came to the therapeutic class (5) things they find easy or difficult to do, and many more ideas the children bring up spontaneously. They realize that this is their opportunity to share any accomplishments, problems, or feelings they have experienced since the last class day. Example: Danny, age 4, was referred because of toileting difficulties. He would tell his friends at talk time how proud he was he could go to the bathroom by himself and told about his star sticker chart at home that was a reward for good behavior.

The classroom materials are chosen to encourage expressive play, cooperative

play, and creative/imaginative play. The use of projective stories, fairy tales, puppets, and creative drama with themes of sibling rivalry, anger, separation, friends, self confidence, etc., allow the children to identify and express their feelings and concerns verbally in a therapeutic supportive setting. With the advantage of two staff members in the class, every issue or situation can be handled with a thorough and positive intervention at the time it happens. Story time and art time are linked together with similar themes. Books and the corresponding therapeutic art project used in the class are attached. (hand out)

The classroom managment techniques begin with class structure with definite rules and limits. Certain rules are talked about the first day of class and some of these include:

1) using words to express feelings and needs instead of physical aggression of hitting, biting, or throwing
2) sharing toys and taking turns with peers
3) all children participate in class activities.

The children are given verbal and physical praise and rewards by the teacher while following the rules of class. Body contact and touch are used as well as sticker charts and stamps for reward and positive reinforcement. If a child is having difficulty following the group activities and rules or teacher's directions, a short time out chair restriction is used with the child sitting on a chair in a designated isolated area of the classroom. The teacher or therapist interprets and dialogues with this child about the reason they are having a time out and the child reflects the rule. Removal from the group is effective as the children want to participate in the activities. Sometimes it is necessary to remove a child from the room if he is becoming out of control, destructive to the room or children, or

disrupting the classroom group. Interpretation of the child's behavior is the mode to connect the child's behavior with his feelings. The staff uses this for all children and they may say:

- "Sometimes it's scary to try something new..."
- "You get angry when the teacher makes you take turns ..."
- "It's hard to be quiet and sit when you have to wait..."
- "It feels good to draw a pretty picture..."
- "It makes you mad when you can't play with all the toys..."
- "Its hard to say goodbye..."

Physical intervention is needed if the child refuses to cooperate and staff needs to physically help him follow the class activities and routine.

The teacher and therapist need to keep a calm supportive attitude with these children and be very consistent, involved with each child, and warmly relate to them with enthusiasm, and understanding.

Home Visits

The home-bound instruction is available for children ages 0-3 showing behavioral, social-emotional, pre-academic, and communicative deficits. These children are visited weekly by the special education teacher and/or child therapist in the home. The first home visit is a diagnostic visit with both the teacher and therapist attending and then the team meets to develop a plan of treatment for the family, including the number of visits, goals for the family, and the type of involvement in conjunction with home visits. Two examples of differing modes of treatment would be: (1)teacher gives individual play therapy in class while the parents are seen individually or (2)teacher/therapist/parent/child play session alternating in the class while the others observe behind the one way mirror.

Occasional evening home visits are made for working fathers to be involved and the child's behavior can be observed at a time later in the day which most parents view as being a difficult time of day to manage their children.

Joey, age 3, presented problems of screaming head banging, severe tantrums, soiling, short attention span, and language difficulties using one word phrases. Home visits helped the staff assess his needs as he was in a non-stimulating, disorganized home environment with no daily routine and little attention given to Joey. He didn't know how or what to play and needed positive experience with age appropriate toys. Some specific ideas used by the teacher in home visits were:

-Teacher explains and demonstrates play interactions and behavior management skills
-parent involvement and interaction in play is encouraged
-homemade materials were made by teacher and parent
-communicating and talking with the child in play was encouraged
-a catalog of toys is used with parents to aid in choosing age level toys for the child
-expression of praise and positive reinforcement of his accomplishment in in play is encouraged
-book lending and toy lending system is utilized with teacher suggestions of parent/child playing with materials together at a specified time
-art activity idea and materials are left at the home for parent to try during the week before the teacher returns on weekly visit
-a daily routine and schedule of beginning day regularly and spending X amount of time with the child is used

Story	Art Project
The Three Pigs	Three Pig Puppets
Susie the Snake	Play dough
Bodies	Body Drawings
Temper Tantrum Book	Feelings Collage
Alexander and the Terrible, Horrible, No Good Very Bad Day	_____and the Terrible Day Book
Betsy's Baby Brother	Water Play washing the baby
The Three Bears	Lace Bear Masks
Leo the Late Bloomer	Leo Lion paper plate puppets
Grownups Cry Too	Paint picture of today's feeling
I hate it	"Things I don't like" book
Don't be scared book	Feelings Wheel on paper plate
The Gingerbread Man	Decorate Gingerbread Men with frosting
There's a Nightmare in my closet	Fingerpaint
Mister Rogers talks about going to the Dr.	Cut and Paste miniature Dr. Kits
Will I Have a Friend	Magazine pictures of what I like to do with my friends